FORM A

WASHINGTON CENTRAL SUPERVISORY UNION
FLEXIBLE BENEFIT ENROLLMENT FORM

EMPLOYEE INFORMATION

EMPLOYEE'S NAME(Please Print)	DATE OF BIRTH	SOCIAL SECURITY #
HOME ADDRESS	CITY, STATE	ZIP CODE
PERSONAL EMAIL ADDRESS	HOME PHONE #	HICN #(IF COVERED BY MEDICARE OR MEDICAID)

SECTION 1: HEALTH FLEXIBLE SPENDING ACCOUNT (MEDICAL SPENDING ACCT)

____ I DO wish to participate in the Health Flexible Spending Account. $______________
Annual amount of salary reduction cannot exceed $2,600.

____ I DO NOT wish to participate in the Health Flexible Spending Account.

SECTION 2: DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DAY CARE)

____ I DO wish to participate in the Dependent Care Flexible Spending Account. $______________
Annual amount of salary reduction cannot exceed $5,000.

____ I DO NOT wish to participate in the Dependent Care Flexible Spending Account.

SECTION 3: CASH IN LIEU OF HEALTH INSURANCE COVERAGE (BCBS OPT OUT)

____ I have completed the "Terms of Medical Plan Cash-in-Lieu Payment" form.
I elect to receive the cash in lieu of health insurance which is taxed as regular income.

SECTION 4: HEALTH AND DENTAL PREMIUMS

ALL PREMIUMS WILL AUTOMATICALLY BE PROCESSED THROUGH THE WASHINGTON CENTRAL SUPERVISORY UNION FLEXIBLE BENEFITS PLAN ON A PRE-TAX BASIS.

CHECK HERE ____ IF YOU ELECT TO PAY TAXES ON THE PREMIUMS.

For office use only

Number of Pay Periods:____________	Effective Date:_______________
Deduction (24 ppds) MED: $____________ DEP: $____________	Date of first P/R:_____________

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WASHINGTON CENTRAL SUPERVISORY UNION
FLEXIBLE BENEFIT ENROLLMENT FORM (CONTINUED – page 2)

FAMILY INFORMATION

DEPENDENT FULL NAME	HICN#(IF COVERED BY MEDICARE/	RELATIONSHIP TO YOU	DATE OF BIRTH	SOCIAL SECURITY #

THOSE NAMED ABOVE, ___ARE___, ARE NOT (CHECK ONE) AUTHORIZED TO DISCUSS THE STATUS OF MY FLEXIBLE BENEFITS ACCOUNTS AND/OR HEALTH REIMBURSEMENT ARRANGEMENT, INCLUDING PAYMENTS OF BENEFITS WITH FUTURE PLANNING ASSOCIATES , INC.

I HAVE READ AND UNDERSTAND THE "OTHER TERMS AND CONDITIONS STATEMENT FOUND ON PAGE 3 BEFORE SIGNING BELOW. I CERTIFY THAT I WISH TO PARTICIPATE IN THE PLAN AND ELECT TO HAVE THE TOTAL AMOUNT STATED DEDUCTED FROM MY PAYCHECKS. I UNDERSTAND THAT THIS WILL LOWER MY TAXABLE WAGES AND CONSEQUENTLY MY SOCIAL SECURITY BASE AMOUNT.

I MUST CONTINUE ENROLLMENT IN THE PLAN WITH MY ABOVE STATED SALARY REDUCTION AMOUNT UNTIL THE END OF THE PLAN YEAR OR MY EMPLOYMENT TERMINATION DATE, WHICHEVER OCCURS FIRST. HOWEVER, IN THE EVENT OF A CHANGE IN MY FAMILY STATUS(IE MARRIAGE, DIVORCE, BIRTH ETC.). I MAY CHANGE OR REVOKE MY SALARY REDUCTION AMOUNT. SHOULD MY REQUIRED CONTRIBUTIONS FOR THE ELECTED BENEFITS BE INCREASED OR DECREASED WHILE THIS AGREEMENT REMAINS IN EFFECT, MY COMPENSATION WILL AUTOMATICALLY BE ADJUSTED TO REFLECT THIS CHANGE.
AT THE END OF THE PLAN YEAR, SHOULD ANY ANNUAL SALARY REDUCTION EXCEED MY ACTUAL ANNUAL EXPENSES, THE EXCESS WILL BE FORFEITED.
SECTION 105 AND 125 DEDUCTIONS ARE PRETAX AND MAY NOT BE ITEMIZED AND DEDUCTED AGAIN WHEN FILING IRS FORM 1040. SHOULD THE COMPANY INCUR A LIABILITY FOR FAILURE TO WITHHOLD FEDERAL, STATE, LOCAL OR FICA TAXES DUE TO FRAUDULENT ACT OF THE EMPLOYEE, THE EMPLOYEE SHALL INDEMNIFY THE COMPANY THAT LIABILITY DEMAND.

EMPLOYEE SIGNATURE	**DATE**

Other Terms and Conditions Statement

I understand that: I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have a change in status. A change in status includes marriage, divorce, annulment, death of a spouse or dependent, birth, adoption or placement for adoption of a child, change of my employment status or that of my spouse or dependent, my or my spouse's or dependent's change in residence or worksite, change in dependent care cost due to a change in provider or fees (fees not applicable if the care provider is a relative), my spouse's or dependent's change in coverage under their employer's Flexible Benefits Plan or other qualified plan (change is not applicable to the health care reimbursement account), my or my spouse's or dependent's change in eligibility for Medicare or Medicaid, or such other events as the Plan Administrator determines will permit a change or revocation of an election. A change must be necessitated by and consistent with the change in status. The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. The redirection in my cash compensation under this agreement shall be in addition to any reductions under other agreements or Benefit programs maintained by my Employer. The amount of my compensation redirection for each pay period during the year will be credited to reimbursement accounts and such amount will be paid on my behalf or I will be reimbursed for the applicable expenses incurred during the plan year. Any amounts that are not used during a plan year to provide Benefits will be forfeited and may not be paid to me in cash or used to provide Benefits for me in a later plan year. **Up to $500 of the year-end account balance in your Health Care Reimbursement Account will automatically be rolled to the new Plan Year and added to your new election.** Prior to the first day of each plan year I will be offered the opportunity to change my Benefit elections for the following plan year.

Premium Payments for employee-paid insurance premiums offered in this Plan will automatically be paid through this Plan unless I elect **not** to participate prior to the beginning of the Plan Year. Furthermore, I understand that my Employer will furnish me with an "Election Not to Participate" form upon my request.

Health care reimbursement will be available for *"qualifying medical care expenses."* Generally, *"qualifying medical care expenses"* are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state and local income tax or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. If I cease my employment with the Employer, my participation in the Health Care Reimbursement Account will continue if I so elect. If I elect to continue participation, my salary redirections will continue with after-tax contributions for the remainder of the plan year. If I elect not to continue participation, no further contributions will be made to the Plan on my behalf, although I may submit claims for expenses incurred during the plan year prior to my date of termination. I cannot seek reimbursement from this Plan for a medical expense which I intend on taking as a deduction on my tax return.

Dependent care reimbursement will be available only for *"qualifying dependent care expenses,"* as described in the Internal Revenue Code Section 129, the plan document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state and local income tax or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

I agree to provide the Plan Administrator with the name, address and the taxpayer identification number of my dependent care service provider (if applicable). I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance plan. My reimbursement account elections will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before reduction hereunder, is at least equal to the amount of that reduction. I have received the Summary Plan Description for this Plan. <u>End of Plan Year claims for expenses incurred on or before December 31st must be submitted by April 1st.</u>

This agreement is subject to the terms of the Washington Central Supervisory Union Flexible Benefits Plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation redirection agreement relating to such plan.